Washington State
Health Care Authority
Public Employees Benefits Board

PEBB Initial Notice of COBRA and Continuation Coverage Rights

HCA 50-800 (4/05)

PEBB contact information

You may obtain information about PEBB eligibility and COBRA and other continuation coverage from:

Mailing address
Health Care Authority
PEBB Benefit Services
P.O. Box 42684
Olympia, WA 98504-2684

Street address
Health Care Authority
PEBB Benefit Services
676 Woodland Square Loop SE
Lacey, WA 98503

Phone: 1-800-200-1004 or 360-412-4200

PEBB Web site: **www.pebb.hca.wa.gov**

You may find the Public Employees Benefits Board's existing laws in chapter 41.05 of the Revised Code of Washington (RCW), and rules in chapters 182-04, 182-08, 182-12, 182-13, and 182-16 of the Washington Administrative Code (WAC). These are available on the Office of the Code Reviser's Web site at **slc.leg.wa.gov**.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

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Introduction

The right to COBRA continuation was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This notice generally explains COBRA coverage when it may become available to you and your family and what you need to do to protect the right to receive it. Certain beneficiaries may not be eligible for COBRA, but may be eligible for other continuation coverage. For more information, review the PEBB Summary Plan Description of Continuation Rights under COBRA and PEBB Rules *or contact PEBB Benefit Services at 1-800-200-1004.*

You are receiving this notice because you have recently become eligible for Public Employees Benefits Board (PEBB) coverage. PEBB is administered by the Washington State Health Care Authority (HCA).

This notice contains important information about your right to COBRA (a temporary extension of PEBB group health coverage) and other continuation coverage available to you and your covered family members under certain circumstances when PEBB coverage would otherwise end.

COBRA or other continuation coverage can become available to you when you would otherwise lose your PEBB group health coverage. It can also become available to your spouse and dependent children when they would otherwise lose PEBB coverage. This notice does not fully describe COBRA, other continuation coverage, or other rights under PEBB. For additional information about your rights and obligations under PEBB and federal law, review the *PEBB Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*.

Simply put, continuation coverage is available to a PEBB enrollee (employee or dependent) who loses PEBB medical or dental coverage if certain events (called "qualifying events") occur that terminate those coverages. Eligible enrollees may elect to continue medical, dental, or both for a limited time on a self-pay basis.

What are COBRA and the other continuation coverage options available under PEBB rules?

There are four continuation coverage options you may be eligible for as a PEBB enrollee:

- COBRA
- PEBB Extension of Coverage
- Leave Without Pay (LWOP) coverage
- PEBB-sponsored retiree coverage

The first three options above temporarily extend group health coverage if certain circumstances occur that would otherwise end your or your dependents' PEBB medical and dental coverage. COBRA continuation coverage is governed completely by eligibility and administrative requirements in federal law and regulation. PEBB Extension of Coverage is an alternative created for PEBB enrollees who are not eligible for COBRA. LWOP coverage is an alternative that may be appropriate in specific situations.

The fourth option above is only available to individuals who meet eligibility criteria defined in Washington Administrative Code (WAC) 182-12-171, or surviving dependents who meet eligibility criteria defined in WAC 182-12-250 or 182-12-265.

All four options are administered by the HCA.

Each continuation coverage option is summarized below:

- If you are enrolled in PEBB health coverage and are a "qualified beneficiary" under federal law, and have a "qualifying event," you may be eligible to continue your PEBB medical and/or dental coverage under **COBRA**.
- If you are enrolled in PEBB health coverage and are not a qualified beneficiary, and have a qualifying event, you will not be eligible for COBRA but may be eligible to continue your medical and/or dental coverage under **PEBB Extension of Coverage**. People who are not qualified beneficiaries under COBRA law include qualified same-sex domestic partners, children of qualified same-sex domestic partners, COBRA beneficiaries who become entitled to Medicare, and retirees and dependents of retirees who cease to be eligible for PEBB-sponsored retiree coverage.
- If you are an employee who will lose your PEBB coverage because you are on authorized leave without pay from your agency, are laid off due to a reduction in force, are receiving time-loss benefits under workers' compensation, are applying for disability retirement, have been called to active military duty, are on approved educational leave, or are a part-time faculty or a reversion employee, you may be entitled to **LWOP coverage**. LWOP coverage allows you and your eligible dependents to continue medical, dental, and life insurance for at least 18 months (and in the some instances, 29 months) as set forth in PEBB rules. See WAC 182-12-133(1) and (2), 182-12-141, and 182-12-148. **Note:** In the case of approved educational leave, you may be entitled to continue long-term disability coverage as well.
- If you are an employee who will lose your PEBB coverage because you are retiring, and meet PEBB eligibility criteria defined in WAC 182-12-171, you and your eligible dependents may be entitled to elect **PEBB-sponsored retiree coverage** to continue medical and dental coverage. You may also be entitled to elect PEBB-sponsored retiree term life insurance.
- If you are a spouse or eligible dependent child of an emergency service employee killed in the line of duty as defined in WAC 182-12-250, you may be entitled to elect **PEBB-sponsored retiree coverage**.

After a qualifying event occurs and you notify PEBB Benefit Services, COBRA coverage must be offered to each person losing PEBB coverage who is a qualified beneficiary. You, your spouse, and your dependent child(ren) could be qualified beneficiaries and would be entitled to elect COBRA continuation coverage if PEBB coverage is lost because of a qualifying event. Certain newborns, newly adopted children, and alternate recipients under Qualified Medical Child Support Orders (QMCSOs) may also be qualified beneficiaries. This is discussed in more detail in the "Other individuals who may be qualified beneficiaries" section.

Who is entitled to elect COBRA?

COBRA qualifying events for the covered employee

If you are an employee, you will be entitled to elect COBRA to continue your PEBB medical and dental coverage if you lose your coverage because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

Qualifying events for the covered spouse

If you are the covered spouse of an employee, you will be entitled to elect COBRA if you lose your PEBB coverage because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee or retiree) reduces or eliminates your PEBB medical or dental coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

Qualifying events for dependent children

If you are the dependent child of an employee, you will be entitled to elect COBRA if you lose your PEBB coverage because any of the following qualifying events happens:

- Your parent (employee or retiree) dies;
- Your parent's (the employee's) hours of employment are reduced; or
- Your parent's (the employee's) employment ends for any reason other than his or her gross misconduct; or
- You stop being eligible for PEBB coverage as a dependent child. (See WAC 182-12-260(3), (4), and (5).)

Who is entitled to elect PEBB Extension of Coverage?

PEBB Extension of Coverage offers continuation of PEBB coverage to PEBB enrollees who are not eligible for federal COBRA coverage.

If you are a retiree or the dependent of a retiree who is no longer eligible for PEBB-sponsored retiree coverage, or you are a qualified same-sex domestic partner or the child of a qualified same-sex domestic partner, you are not a qualified beneficiary under federal law; however, PEBB Extension of Coverage may be available to you as set forth in WAC

182-12-111(4)(g) and 182-12-270(3). If you are a COBRA enrollee who becomes entitled to Medicare, you are not a qualified beneficiary under federal law; however PEBB Extension of Coverage may also be available to you.

To preserve your rights for this coverage, you must meet the eligibility, notice, and procedure requirements described in the *PEBB Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*.

Qualifying events for the covered retiree

If you are a retiree who is no longer eligible for PEBB-sponsored retiree coverage, you and your dependents may be entitled to elect 18 months (subject to extension or early termination) of PEBB Extension of Coverage if you lose your PEBB medical or dental coverage because either one of the following events happens:

- Your employer group terminates PEBB plan participation; or
- You are determined no longer disabled by the Department of Retirement Systems and stop receiving a retirement pension.

Qualifying events for qualified same-sex domestic partners and their child(ren)

If you are an employee's or retiree's covered same-sex domestic partner, or the covered dependent child of a same-sex domestic partner, you may be entitled to elect 36 months (subject to early termination) of PEBB Extension of Coverage if you lose your PEBB coverage because any of the following qualifying events happens:

- The employee or retiree dies, and you do not qualify for surviving dependent coverage as defined in WAC 182-12-265;
- The employee's hours of employment are reduced;
- The employee's employment ends for any reason other than his or her gross misconduct;
- The qualified same-sex domestic partnership is dissolved; or
- As a dependent child of a qualified same-sex domestic partner, you are no longer eligible for PEBB coverage as a dependent child as defined in WAC 182-12-260(3), (4) or (5).

Who is entitled to elect LWOP coverage?

Qualifying events for the covered employee

If you are an employee who will lose your PEBB coverage because of one of the following events, you may be entitled to elect LWOP coverage to continue PEBB medical, dental, or life insurance coverage (and in the case of approved educational leave, long-term disability coverage) for you and your covered dependents for 29 months as set forth in PEBB rules (see WAC 182-12-133(1)) and described below:

- You are on an authorized leave without pay from your agency;
- You are laid off because of a reduction in force (RIF);
- You are receiving time-loss benefits under workers compensation;

- You are applying for disability retirement;
- You are called to active military duty (employees called to active military duty may only continue life insurance for 12 months); or
- You are on approved educational leave (employees on educational leave may continue long-term disability for a maximum of 24 months).

Part-time faculty and employees who revert

If you are an employee who will lose your PEBB coverage because of one of the following events, you may be entitled to elect LWOP coverage to continue your PEBB medical, dental, and life insurance coverage for you and your covered dependents for 18 months as set forth in PEBB rules and described below:

- You are a part-time faculty member between periods of eligibility (see WAC 182-12-133(2)); or
- You are an employee who reverted and are not eligible for employer-sponsored benefits (see WAC 182-12-141).

Dismissed employees appealing dismissal

If you are an employee who will lose your PEBB coverage because of a dismissal, you may be entitled to elect LWOP coverage to continue your PEBB medical, dental, and life insurance coverage. LWOP coverage may be available for you and your covered dependents for a maximum of 18 months or the end of the month in which a decision is reached on your appeal of the dismissal and premiums have been paid, whichever is earlier (see WAC 182-12-148).

Who is entitled to elect PEBB-sponsored retiree coverage?

Employees

If you are an eligible employee who terminates your PEBB coverage after becoming vested in a Washington state-sponsored retirement system, and you are eligible as defined in PEBB rules (see WAC 182-12-171), you may be entitled to elect PEBB-sponsored retiree coverage to continue PEBB medical and dental coverage for you and your eligible dependents. You may also be entitled to elect enrollment in PEBB-sponsored retiree term life insurance.

Dependents

You may be entitled to elect PEBB-sponsored retiree coverage if you are a:

- Spouse or eligible dependent child of an emergency service employee killed in the line of duty, and you meet eligibility as defined in WAC 182-12-250;
- Spouse, qualified same-sex domestic partner, or eligible dependent child of a deceased eligible **employee**, and you meet eligibility defined in WAC 182-12-265(1)(a) or (b);

- Spouse, qualified same-sex domestic partner, or eligible dependent child of a deceased eligible **retiree**, and you meet eligibility as defined in WAC 182-12-265(2); or
- Spouse, qualified same-sex domestic partner, or eligible dependent child of a deceased **school district or educational service district employee**, and you meet eligibility as defined in WAC 182-12-265(3).

When is COBRA or other continuation coverage available?

The appropriate continuation coverage will be offered to qualified beneficiaries only after PEBB Benefit Services has been notified that a qualifying event has occurred.

Your **employer** must notify PEBB Benefit Services when **any** of these qualifying events occurs:

- The employee's employment ends;
- The employee's hours of employment are reduced; or
- The death of the employee.

You must notify PEBB Benefit Services of other qualifying events, such as:

- Divorce, legal separation, or dissolution of a qualified same-sex domestic partnership; or
- When a dependent child loses eligibility for PEBB coverage.

You must notify PEBB Benefit Services in writing within **60 days** after the latter of: (a) the date of the qualifying event; or (b) the date the qualified beneficiary loses (or would lose) coverage under PEBB rules as a result of the qualifying event, as defined in chapter 182-12 WAC.

In providing this notice, you must use the attached *Notice of Qualifying Event (Form and Notice Procedures)* form and follow the notice procedures. If these procedures are not followed, or if the notice is not provided in writing to PEBB Benefit Services within 60 days, **you will lose your right to elect COBRA or other continuation coverage.**

Electing COBRA or other continuation coverage

Each qualified beneficiary will have an independent right to elect COBRA or other continuation coverage. For example:

- The employee's spouse may elect continuation coverage, even if the employee does not.
- Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries.
- Covered employees and spouses (if the spouse is a qualified beneficiary) may elect continuation coverage on behalf of all of the qualified beneficiaries, and parents may elect continuation coverage on behalf of their eligible children.

Any qualified beneficiary for whom continuation coverage is not elected within the 60-day period specified in the PEBB election notice will lose his or her right to elect COBRA and all other continuation coverage options.

Qualified beneficiaries may be enrolled in PEBB medical and/or dental coverage at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he or she may elect COBRA medical and/or dental coverage from the plan(s) he or she was covered under on the day before the qualifying event. (For example, if a qualified beneficiary had medical and dental coverage on the day before a qualifying event, he or she may elect COBRA dental coverage only, medical coverage only, or both medical and dental.)

Beneficiaries who are not qualified under federal COBRA law may be able to elect PEBB Extension of Coverage as a result of the qualifying event. If a beneficiary is entitled to PEBB Extension of Coverage, he or she may elect PEBB medical and/or dental coverage from the plan(s) he or she was covered under on the day before the qualifying event.

People who are entitled to elect COBRA or other continuation coverage may do so even if they have other group health coverage or are entitled to Medicare on or before the date the continuation coverage is elected. However, as discussed in more detail in the *Summary Plan Description*, a beneficiary's continuation coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare. A beneficiary's continuation coverage will also end early if, after electing COBRA or PEBB Extension of Coverage, he or she becomes covered under other group health coverage (but only after any applicable preexisting condition exclusion periods of that other plan have been exhausted or satisfied). See "Termination of COBRA or other continuation coverage options before the end of the maximum coverage period" in the *Summary Plan Description*.

How long does continuation coverage last?

COBRA, PEBB Extension of Coverage, and **LWOP coverage** provide a temporary continuation of coverage. The periods described below are maximum coverage periods. Coverage can end before the end of the maximum coverage period for several reasons, which are described in the "Termination of COBRA and other continuation coverage options before the end of the maximum coverage period" section of the *Summary Plan Description*.

When the qualifying event is death, divorce, legal separation, dissolution of a qualified same-sex domestic partnership, or child's loss of dependent status

- When PEBB coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child stops being eligible (as defined in WAC 182-12-260), COBRA coverage can last up to 36 months.
- When PEBB coverage is lost due to the death of the employee, the covered employee's dissolution of a qualified same-sex

domestic partnership, or a dependent child of a same-sex domestic partnership stops being eligible (as defined in WAC 182-12-260), PEBB Extension of Coverage can last up to 36 months.

When the qualifying event is death of an employee or retiree

Surviving dependents who meet PEBB eligibility (as set forth in WAC 182-12-250 and 182-12-265) may be eligible to continue coverage under PEBB-sponsored retiree coverage for the maximum period described below:

- The spouse or qualified same-sex domestic partner may continue coverage until death.
- The dependent children may continue coverage until they are no longer eligible (as defined in WAC 182-12-260).

When the covered employee becomes entitled to Medicare within 18 months before his or her termination of employment or reduction of hours

When PEBB coverage is lost due to the end of employment or reduction of the employee's hours, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, continuation coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare eight months before the date employment terminates, continuation coverage for the spouse and children who lost coverage as a result of termination of employment can last up to 36 months after the date of Medicare entitlement. This equals 28 months after the date of the qualifying event (36 months minus eight months).

This continuation coverage period is available only if the covered employee becomes entitled to Medicare within 18 months **before** termination of employment or reduction of hours.

When the qualifying event is a termination of employment or reduction of hours

When PEBB coverage is lost due to the end of employment or reduction of the employee's hours, continuation coverage generally can last for up to 18 months, subject to other provisions in this booklet.

Limited right to a maximum of 29 months for employees on approved LWOP

When PEBB coverage is lost because of one of the following events, continuation coverage generally can last for a maximum of 29 months as set forth in WAC 182-12-133(1) and described below:

- You are on an authorized leave without pay from your agency;
- You are laid off because of a reduction in force (RIF);
- You are receiving time-loss benefits under workers' compensation;
- You are applying for disability retirement;

- You are called to active military duty. (Employees called to active military duty may only continue PEBB life insurance for 12 months); or
- You are on approved educational leave. (Employees on educational leave may continue long-term disability for a maximum of 24 months.)

If these procedures are not followed or if notice is not provided in writing to PEBB Benefit Services during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage.

Limited right to an extension of the COBRA or LWOP coverage period

An extension of the maximum 18-month period of continuation coverage available under COBRA or LWOP coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs.

You must notify PEBB Benefit Services of a disability or a second qualifying event to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of continuation coverage. These extension opportunities do **not** apply to continuation coverage resulting from a covered employee's death, divorce or legal separation, dissolution of a qualified same-sex domestic partnership, or a dependent child's loss of eligibility.

Disability extension of COBRA, PEBB Extension of Coverage, or LWOP coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify PEBB Benefit Services in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of continuation coverage, for a total of 29 months. This extension is available only for qualified beneficiaries who are receiving continuation coverage because of a qualifying event (the covered employee's termination of employment or reduction of hours).

The disability must have started before the 61st day after the covered employee's termination of employment or reduction of hours, and must last at least until the end of the continuation coverage period available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

Deadline

The disability extension is available only if you notify PEBB Benefit Services in writing within **60 days** after the latter of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; or
- The date the qualified beneficiary loses (or would lose) coverage under PEBB rules as a result of the covered employee's termination of employment or reduction of hours.

To elect a disability extension, you must use the *Notice of Disability (Form and Notice Procedures)* form found in this booklet and follow the notice procedures.

If these procedures are not followed, or if the notice is not provided in writing to PEBB Benefit Services during the 60-day notice period, then there will be no extension of coverage due to a second qualifying event.

Second qualifying-event extension of COBRA, PEBB Extension of Coverage, or LWOP coverage options

An extension of COBRA, PEBB Extension of Coverage, or LWOP coverage may be available to spouses, qualified same-sex domestic partners, and dependent children who are receiving continuation coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension or for some LWOP coverage enrollees, 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months.

Second qualifying events may include the death of a covered employee, divorce or legal separation, dissolution of a qualified same-sex domestic partnership, or a dependent child's ceasing to be eligible for coverage under PEBB rules. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under PEBB rules if the first qualifying event had not occurred.

Extension of coverage due to a second qualifying event is available only if you notify PEBB Benefit Services in writing of the second qualifying event within **60 days** after the latter of:

- The date of the second qualifying event; or
- The date the qualified beneficiary would lose coverage under PEBB rules as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the PEBB plan).

To elect a second qualifying-event extension, you must use the *Notice of Second Qualifying Event (Form and Notice Procedures)* form (available from PEBB Benefit Services) and follow the notice procedures.

Termination of COBRA and other continuation coverage options before the end of the maximum coverage period

(1) Automatic termination before the end of the maximum coverage period

COBRA and other continuation coverage options will automatically terminate before the end of the maximum period if:

(a) Any required premium is not paid in full on time;

(b) After electing COBRA or PEBB Extension of Coverage, a qualified beneficiary becomes covered under another group health plan (but only after any preexisting condition exclusions of that other plan have been exhausted or satisfied, and the qualified beneficiary is not continuing benefits under PEBB LWOP or retiree coverage);

(c) A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA; however, the qualified beneficiary will be eligible to continue coverage under the PEBB Extension of Coverage option until the end of his or her original COBRA period; or

(d) The employer ceases to provide any group health plan for its employees (this is particularly important for people eligible through an employer group such as a political subdivision); or

(e) During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. (For more information about the disability extension period, see the "Limited right to an extension of the COBRA or LWOP coverage period" section starting on page 11.)

(f) Continuation coverage may also be terminated for any reason coverage would terminate for any other PEBB enrollee (such as fraud).

(2) Medicare entitlement or other coverage

You must notify PEBB Benefit Services in writing within **60 days** if, after electing continuation coverage, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied).

You must use the *Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form and Notice Procedures)* form, and follow the procedures specified in the "Procedures for notice of other coverage, Medicare entitlement, or cessation of disability" section.

(3) You must notify PEBB Benefit Services if a qualified beneficiary ceases to be disabled

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify PEBB Benefit Services within **60 days** after the Social Security Administration's determination.

You must use the *Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form and Notice Procedures)* form, and follow the procedures specified in the "Procedures for notice of other coverage, Medicare entitlement, or cessation of disability" section. (See Appendix E.)

(4) Termination of COBRA, PEBB Extension of Coverage or the LWOP option when qualified beneficiary ceases to be disabled

If the Social Security Administration determines that the qualified beneficiary is no longer disabled, and this determination occurs during a disability extension period, COBRA, PEBB Extension of Coverage, or LWOP coverage for all qualified beneficiaries will terminate (retroactively, if applicable) as of the first day of

the month that is more than 60 days after the Social Security Administration's determination.

You are liable for repayment of all benefits paid after the termination date, whether or not you provide notice to PEBB Benefit Services that the disabled qualified beneficiary is no longer disabled.

For more information about the disability extension period, see the "Limited right to an extension of the COBRA or LWOP coverage period" section starting on page 11.

Other individuals who may be qualified beneficiaries

Children born to or placed for adoption with the covered employee during a period of continuation coverage

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA or other continuation coverage is considered to be a qualified beneficiary, provided that the employee has elected COBRA or other continuation coverage for himself or herself.

The child's COBRA coverage begins when the child is enrolled in PEBB coverage, whether through special enrollment or open enrollment. Coverage lasts for as long as the continuation coverage for the employee's other family members.

To be enrolled in PEBB, the child must satisfy the otherwise applicable PEBB eligibility requirements (for example, regarding age). See WAC 182-12-260(3), (4), and (5).

Alternate recipients under QMCSOs

A child of the covered employee who is receiving PEBB benefits pursuant to a Qualified Medical Child Support Order (QMCSO) received by PEBB Benefit Services is entitled to the same rights to elect COBRA or other continuation coverage as an eligible dependent child of the covered employee.

If you have questions

Questions concerning your PEBB eligibility or your COBRA or other continuation coverage rights should be addressed to PEBB Benefit Services.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other federal laws affecting group health plans, contact the nearest regional or district office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at **www.dol.gov/ebsa**. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's Web site.)

Notify PEBB Benefit Services of address changes

To protect your family's rights, you should keep PEBB Benefit Services and your employer informed of any changes in the addresses of family members. You should also keep a copy of any notices you send to the HCA for your records.

PEBB contact information

You may obtain information about PEBB eligibility and COBRA coverage from:

Mailing address
Health Care Authority
PEBB Benefit Services
P.O. Box 42684
Olympia, WA 98504-2684

Street address
Health Care Authority
PEBB Benefit Services
676 Woodland Square Loop SE
Lacey, WA 98503

Phone: 1-800-200-1004 or 360-412-4200

The contact information for the HCA/PEBB Benefit Services may change from time to time. The most recent information will be included in the current version of this document. (If you are not sure whether this is the most recent version, you may request one from PEBB Benefit Services.)

You can also find more information about PEBB online at **www.pebb.hca.wa.gov**.

Public Employees Benefits Board (PEBB)

Notice of Qualifying Event (Form and Notice Procedures)

This form, including the "Procedures for Notice of Qualifying Event" section, is part of the *PEBB Initial Notice of COBRA and Continuation Coverage Rights* booklet. For more information about this form, the PEBB's notice procedures, and your COBRA rights and obligations, consult the *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*, and other sections of the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. These documents are available by calling PEBB Benefit Services at 1-800-200-1004.

When to use this form

Use this form when any of the following qualifying events occurs:

- Divorce;
- Legal separation;
- Dissolution of a qualified same-sex domestic partnership;
- A covered employee reduced or eliminated his or her spouse's PEBB coverage in anticipation of their divorce or legal separation, and the anticipated divorce or legal separation has subsequently occurred; or
- A child enrolled in PEBB coverage is no longer eligible under PEBB rules (as set forth in chapter 182-12 of the Washington Administrative Code [WAC]).

Deadline

The deadline for providing this notice is **60 days** after the latter of:

- The date of the qualifying event (i.e., divorce, legal separation, dissolution of a qualified same-sex domestic partnership, or a child's loss of dependent status); or
- The date the covered spouse, qualified same-sex domestic partner, or dependent child would lose PEBB coverage as a result of the qualifying event.

If your notice is late, or if it is not completed and provided to PEBB Benefit Services as described in the "Procedures for Notice of Qualifying Event" section, no beneficiary will be offered the opportunity to elect COBRA or other continuation coverage.

HCA 50-818 (1/05)

Procedures for Notice of Qualifying Event

How to provide notice

Your notice **must** be in writing (using the PEBB form included in this notice) and either mailed or hand-delivered. Oral notice (in person or by telephone) and electronic notice (fax or e-mail) is not acceptable.

If mailed, your notice must be postmarked no later than the deadline described in these procedures. If hand-delivered, your notice must be received by PEBB Benefit Services at the address below no later than the deadline described in these procedures.

Where to provide notice

Mailing address
Health Care Authority
PEBB Benefit Services
P.O. Box 42684
Olympia, WA 98504-2684

Street address (for hand deliveries)
Health Care Authority
PEBB Benefit Services
676 Woodland Square Loop SE
Lacey, WA 98503

Required form and information

You **must** use the *Notice of Qualifying Event* form to notify PEBB Benefit Services of a qualifying event (i.e., divorce, legal separation, dissolution of a qualified same-sex domestic partnership, or a child's loss of dependent status). All of the applicable items on the form must be completed.

If you are notifying PEBB Benefit Services of a **divorce or legal separation**, your notice must include a copy of the decree of divorce or legal separation.

If you are notifying PEBB Benefit Services of the **dissolution of a qualified same-sex domestic partnership**, you must include the date the same-sex domestic partner ceased to meet PEBB eligibility as set forth in the *Declaration of Marriage or Same-Sex Domestic Partnership* form.

If you are notifying PEBB Benefit Services that your **PEBB coverage will be reduced or eliminated in anticipation of a divorce, legal separation, or dissolution of a qualified same-sex domestic partnership**, you must provide notice within **60 days** after the divorce, legal separation, or dissolution of a qualified same-sex domestic partnership. In addition, you must provide evidence satisfactory to PEBB Benefit Services that your coverage was reduced or eliminated in anticipation of the divorce, legal separation, or dissolution of a qualified same-sex domestic partnership.

Incomplete notice

If you provide a written notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely only if **all** of the following conditions are met:

- The notice is mailed or hand-delivered to PEBB Benefit Services at the address specified in these notice procedures;
- The notice is provided by the deadline described in this document;
- From the written notice provided, PEBB Benefit Services is able to determine that the notice relates to PEBB coverage;
- From the written notice provided, PEBB Benefit Services is able to identify the covered employee and qualified beneficiary(ies), the qualifying event (divorce, legal separation, dissolution of a qualified same-sex domestic partnership, or child's loss of dependent status), and the date the qualifying event occurred; and
- The additional information and documentation necessary to meet PEBB requirements (as described in these notice procedures) is provided in writing within **15 business days** after a written or oral request from

PEBB Benefit Services for more information (or, if later, by the deadline for the notice of qualifying event described in these procedures).

If any of these conditions are not met, the incomplete notice will be rejected and COBRA or other continuation coverage options will not be offered. If all of these conditions are met, PEBB Benefit Services will treat the notice as having been provided on time.

Who may provide notice

The employee or former employee who is or was covered under PEBB coverage, a qualified beneficiary (with respect to the qualifying event), or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

Additional evidence of the date of a child's loss of dependent status may be required

If your notice was regarding a child's loss of dependent status, and PEBB Benefit Services requests it, you **must** provide satisfactory documentation of the date of the qualifying event within **15 business days**. For example, this could include a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript or other satisfactory evidence showing the last date of enrollment in an educational institution. This will allow PEBB Benefit Services to determine if you gave timely notice of the qualifying event, and were consequently entitled to elect COBRA or other continuation coverage.

If you do not provide satisfactory evidence within this timeframe after a written or oral request from PEBB Benefit Services, the child's continuation coverage may be terminated (retroactively if applicable) as of the date that continuation coverage would have started.

The Health Care Authority (HCA) will require repayment to the health plan of all benefits paid after the termination date.

Washington State Health Care Authority
Public Employees Benefits Board

Notice of Qualifying Event

Type or print clearly in black ink.

Identify the employee or retiree who was enrolled in PEBB coverage

Print name of employee	Social security number
Print name of retiree	Social security number

Address of employee or retiree

Event description (check one and complete)

SPOUSE OR SAME-SEX DOMESTIC PARTNER

☐ Divorce Date ____/____/____

☐ Legally separated Date ____/____/____

☐ Dissolution of a qualified same-sex domestic partnership Date ____/____/____

Print name of spouse or same-sex domestic partner

Address of spouse or same-sex domestic partner

DEPENDENT CHILD

☐ Attained age that is no longer eligible for PEBB coverage

☐ Loss of student status

☐ Loss of dependent status through divorce, legal separation, or dissolution of a qualified same-sex domestic partnership

☐ Married

☐ Other (explain) ____/____/____

Date of event causing loss of dependent eligiblity ____

Print name of child

Relationship to employee or retiree

Address of child (if different than employee's)

(continued on next page)

Certification, signature, and date

I certify that the above information is true and correct.

I am the (check one): ☐ Employee or former employee

☐ Retiree

☐ Spouse or former spouse

☐ Qualified same-sex domestic partner or former qualified same-sex domestic partner

☐ Former dependent child of a qualified same-sex domestic partnership

☐ Former dependent child

☐ Other (explain) _____

Signature	Date
Print name	Telephone number ( )

Address

_____

_____

_____

Please sign and date this form.

Return to:

Washington State Health Care Authority, PEBB Benefit Services, P.O. Box 42684, Olympia, WA 98504-2684

Washington State law may require disclosure of any information you submit as a public record.
The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Visit our Web site at www.pebb.hca.wa.gov

For HCA Use Only

Date notice of qualifying event received _____ Date of postmark, if mailed _____

Decree of divorce or legal separation enclosed? ☐ Yes ☐ No ☐ N/A

Satisfactory evidence that elimination or reduction of coverage was in anticipation of divorce, legal separation, or dissolution of qualified same-sex domestic partnership? ☐ Yes ☐ No ☐ N/A

Public Employees Benefits Board (PEBB)

Notice of Disability (Form and Notice Procedures)

This form, including the "Procedures for Notice of Disability" section, is part of the *PEBB Initial Notice of COBRA and Continuation Rights* booklet. For more information about this form, the PEBB's notice procedures, and your COBRA rights and obligations, consult the *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*, and other sections of the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. These documents are available by calling PEBB Benefits Services at 1-800-200-1004.

When to use this form

You and your family may be entitled to receive up to an additional 11 months of continuation coverage, for a total of 29 months. This extension is available only for qualified beneficiaries who are receiving continuation coverage because of a qualifying event (the covered employee's termination of employment or reduction of hours).

Use this form when the Social Security Administration has determined that a qualified beneficiary was disabled on any day within the first 60 days following a qualifying event due to the covered employee's termination of employment or reduction of hours. **Note:** If the Social Security Administration made the disability determination before the covered employee's termination of employment or reduction of hours, you may still use this form, so long as the qualified beneficiary remains disabled and you provide notice by the deadline described below.

Deadline

The deadline for providing this notice is **60 days** after the latter of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; or
- The date the qualified beneficiary would lose PEBB coverage as a result of the termination of employment or reduction of hours.

Your notice of disability must also be provided within **18 months** after the covered employee's termination of employment or reduction of hours.

If your notice is late, or if it is not completed and provided to PEBB Benefit Services as described in the "Procedures for Notice of Disability" section, no beneficiary will be offered the opportunity to elect COBRA or other continuation coverage.

Procedures for Notice of Disability

How to provide notice

Your notice **must** be in writing (using the PEBB form included in this notice) and either mailed or hand-delivered. Oral notice (in person or by telephone) and electronic notice (fax or e-mail) is not acceptable.

If mailed, your notice must be postmarked no later than the deadline described in these procedures. If hand-delivered, your notice must be received by PEBB Benefit Services at the address below no later than the deadline described in these procedures.

Where to provide notice

Mailing address
Health Care Authority
PEBB Benefit Services
P.O. Box 42684
Olympia, WA 98504-2684

Street address (for hand deliveries)
Health Care Authority
PEBB Benefit Services
676 Woodland Square Loop SE
Lacey, WA 98503

Required form and information

You **must** use the *Notice of Disability (Form and Notice Procedures)* form to notify PEBB Benefit Services of a qualified beneficiary's disability. All of the applicable items on the form must be completed.

Incomplete notice

If you provide a written notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely only if **all** of the following conditions are met**:**

- The notice is mailed or hand-delivered to PEBB Benefit Services at the address specified in these notice procedures;
- The notice is provided by the deadline described in this document;
- From the written notice provided, PEBB Benefit Services is able to determine that the notice relates to PEBB coverage and a qualified beneficiary's disability;
- From the written notice provided, PEBB Benefit Services is able to identify the covered employee and qualified beneficiary(ies), and the date the covered employee's termination of employment or reduction of hours occurred; and
- The additional information and documentation necessary to meet PEBB requirements (as described in these notice procedures) is provided within **15 business days** after a written or oral request from PEBB Benefit Services for more information (or, if later, by the deadline for the notice of disability described above).

If any of these conditions are not met, the incomplete notice will be rejected and COBRA or other continuation coverage will not be extended. If all of these conditions are met, PEBB Benefit Services will treat the notice as having been provided on time.

Who may provide notice

The employee or former employee who is or was covered under PEBB coverage, a qualified beneficiary who lost coverage due to the covered employee's termination of employment or reduction of hours and is still receiving continuation coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA, PEBB Extension of Coverage, or Leave Without Pay (LWOP) coverage period due to the disability reported in the notice.

Washington State Health Care Authority
Public Employees Benefits Board

Notice of Disability

Type or print clearly in black ink.

Identify the employee or retiree who was enrolled in PEBB coverage

Print name of employee	Social security number
Print name of retiree	Social security number

Address of employee or retiree

Identify the initial qualifying event

☐ **Termination of employment**

☐ **Reduction of hours**

☐ **Leave Without Pay (LWOP)**
Loss of employer coverage due to one of the following:
- Part-time faculty member between periods of eligibility (see WAC 182-12-133(2)); or
- Employee reverted and was not eligible for employer-paid benefits (see WAC 182-12-141).

☐ **Extension of Coverage**
Loss of retiree eligibility due to one of the following:
- Employer group terminated PEBB plan participation; or
- Retiree was determined no longer disabled by the Department of Retirement Systems and stopped receiving a retirement pension.

Identify all qualified beneficiaries

Print name(s) of all qualified beneficiaries who lost coverage due to the initial qualifying event who are still receiving continuation coverage.

Is the address of each qualified beneficiary the same as the employee or retiree? ☐ Yes ☐ No If different, provide address below:

(continued on next page)

Identify disabled qualified beneficiary

Print name of disabled beneficiary

Is the address of each qualified beneficiary the same as the employee or retiree? ☐ Yes ☐ No If different, provide address below:

Social Security Administration's determination of disability

Date of Social Security Administration determination _____/_____/_____

A copy of the Social Security Administration's determination is required with this notice.

Has the Social Security Administration subsequently determined that the qualified beneficiary is no longer disabled? ☐ Yes ☐ No

Certification, signature, and date

I certify that the above information is true and correct.

I am the (check one): ☐ Former employee

☐ Spouse

☐ Qualified same-sex domestic partner

☐ Dependent child

☐ Other (explain) _____

Signature	Date
Print name	Telephone number ( )

Address

Please sign and date this form.

Return to: Washington State Health Care Authority, PEBB Benefit Services, P.O. Box 42684, Olympia, WA 98504-2684

Washington State law may require disclosure of any information you submit as a public record.
The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Visit our Web site at www.pebb.hca.wa.gov

For HCA Use Only

Date notice of disability received _____ Date of postmark, if mailed _____

Social Security Administration determination enclosed? ☐ Yes ☐ No ☐ N/A

Public Employees Benefits Board (PEBB)

Notice of Second Qualifying Event (Form and Notice Procedures)

This form, including the "Procedures for Notice of Second Qualifying Event" section, is part of the *PEBB Initial Notice of COBRA and Continuation Coverage Rights* booklet. For more information about this form, the PEBB's notice procedures, and your COBRA rights and obligations, consult the *PEBB Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*, and other sections of the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. These documents are available by calling PEBB Benefit Services at 1-800-200-1004.

When to use this form

An extension of coverage may be available to spouses, qualified same-sex domestic partners, and dependent children who are receiving continuation coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension or for some LWOP coverage enrollees, 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months.

Use this form when any of the following events (second qualifying events) occurs:

- A spouse who is receiving PEBB continuation coverage becomes divorced or legally separated from the covered employee;
- Dissolution of a qualified same-sex domestic partnership;
- A child who is receiving PEBB continuation coverage is no longer eligible under PEBB rules (as set forth in chapter 182-12 of the Washington Administrative Code [WAC]); or
- The covered employee dies while one or more qualified beneficiaries are receiving COBRA or other continuation coverage.

Deadline

The deadline for providing this notice is **60 days** after the latter of:

- The date of the second qualifying event (i.e., divorce, legal separation, dissolution of a qualified same-sex domestic partnership, the covered employee's death, or a child's loss of dependent status); or
- The date the covered spouse, qualified same-sex domestic partner, or dependent child would lose PEBB coverage as a result of the second qualifying event (if this event had occurred while the qualified beneficiary was still covered under PEBB coverage).

If your notice is late, or if it is not completed and provided to PEBB Benefit Services as described in the "Procedures for Notice of Second Qualifying Event" section, no beneficiary will be offered the opportunity to elect extended COBRA or other continuation coverage.

Procedures for Notice of Second Qualifying Event

How to provide notice

Your notice **must** be in writing (using the PEBB form included in this notice) and either mailed or hand-delivered. Oral notice (in person or by telephone) and electronic notice (fax or e-mail) is not acceptable.

If mailed, your notice must be postmarked no later than the deadline described in these procedures. If hand-delivered, your notice must be received by PEBB Benefit Services at the address below no later than the deadline described in these procedures.

Mailing address
Health Care Authority
PEBB Benefit Services
P.O. Box 42684
Olympia, WA 98504-2684

Street address (for hand deliveries)
Health Care Authority
PEBB Benefit Services
676 Woodland Square Loop SE
Lacey, WA 98503

Required form and information

You **must** use the *Notice of Second Qualifying Event (Form and Notice Procedures)* form to notify PEBB Benefit Services of a second qualifying event (i.e., a divorce, legal separation, dissolution of a qualified same-sex domestic partnership, the covered employee's death, or a child's loss of dependent status). All of the applicable items on the form must be completed.

If you are notifying PEBB Benefit Services of a **divorce or legal separation**, you must also include a copy of the decree of divorce or legal separation.

If you are notifying PEBB Benefit Services of the **dissolution of a qualified same-sex domestic partnership**, you must also include the date the same-sex domestic partner ceased to meet PEBB eligibility as set forth in the *Declaration of Marriage or Same-Sex Domestic Partnership* form.

Incomplete notice

If you provide a written notice that does not contain all of the information and documentation required by these notice procedures, such a notice will nevertheless be considered timely only if **all** of the following conditions are met**:**

- The notice is mailed or hand-delivered to PEBB Benefit Services at the address specified in these notice procedures;
- The notice is provided by the deadline described in this document;
- From the written notice provided, PEBB Benefit Services is able to determine that the notice relates to PEBB coverage;
- From the written notice provided, PEBB Benefit Services is able to identify the covered employee and qualified beneficiary(ies), the first qualifying event (the covered employee's termination of employment or reduction of hours), the date the first qualifying event occurred, the second qualifying event, and the date the second qualifying occurred; and
- The additional information and documentation necessary to meet PEBB requirements (as described in these notice procedures) is provided in writing within **15 business days** after a written or oral request from PEBB Benefit Services for more information (or, if later, by the deadline for the notice of second qualifying event described above).

If any of these conditions are not met, the incomplete notice will be rejected and COBRA or other continuation coverage will not be extended. If all of these conditions are met, PEBB Benefit Services will treat the notice as having been provided on time.

Who may provide notice

The employee or former employee who is or was covered under PEBB coverage, a qualified beneficiary who lost coverage due to the covered employee's termination of employment or reduction of hours and is still receiving COBRA or other continuation coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA, PEBB Extension of Coverage, or Leave Without Pay (LWOP) coverage period due to the second qualifying event described in the notice.

Additional evidence of the date of a child's loss of dependent status may be required

If your notice was regarding a child's loss of dependent status, and PEBB Benefit Services requests it, you **must** provide satisfactory documentation of the date of the qualifying event within **15 business days.** For example, this could include a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript or other satisfactory evidence showing the last date of enrollment in an educational institution. This will allow PEBB Benefit Services to determine if you gave timely notice of the second qualifying event, and were consequently entitled to an extension of continuation coverage.

If you do not provide satisfactory evidence within this timeframe after a written or oral request from PEBB Benefit Services, the child's continuation coverage may be terminated (retroactively if applicable) as of the date that COBRA or other continuation coverage would have ended without an extension due to loss of dependent status.

The Health Care Authority (HCA) will require repayment to the health plan of all benefits paid after the termination date.

Additional evidence of the date of the covered employee's death may be required

If your notice was regarding the death of the covered employee, upon request of PEBB Benefit Services, you **must** provide satisfactory documentation of the date of death within **15 business days** (for example, a death certificate or published obituary). This will allow PEBB Benefit Services to determine if you gave timely notice of the second qualifying event, and were consequently entitled to an extension of COBRA or other continuation coverage.

If you do not provide satisfactory evidence within this timeframe after a written or oral request from PEBB Benefit Services, the qualified beneficiaries' continuation coverage may be terminated (retroactively if applicable) as of the date that COBRA, PEBB Extension of Coverage, or Leave Without Pay (LWOP) coverage would have ended without an extension due to the covered employee's death.

The Health Care Authority (HCA) will require repayment to the health plan of all benefits paid after the termination date.

Washington State Health Care Authority
Public Employees Benefits Board

Notice of Second Qualifying Event

Type or print clearly in black ink.

Identify the employee or retiree who was covered under PEBB coverage

Print name of employee	Social security number
Print name of retiree	Social security number

Address of employee or retiree

Identify the initial qualifying event

☐ **Termination of employment**

☐ **Reduction of hours**

☐ **Leave Without Pay (LWOP)**
Loss of employee eligibility for employer coverage due to one of the following:

- Authorized leave without pay (LWOP) from employing agency;
- Layoff because of a reduction in force (RIF);
- Receipt of time-loss benefits under workers' compensation;
- Application for disability retirement;
- Call to active military duty (employees called to active military duty may only continue PEBB life insurance for 12 months);
- Approved educational leave (employees on educational leave may continue long-term disability for a maximum of 24 months);
- Part-time faculty member between periods of eligibility (see WAC 182-12-133(2)); or
- Employee reverted and was not eligible for employer-paid benefits (see WAC 182-12-141).

☐ **Extension of Coverage**
Loss of retiree eligibility due to one of the following:

- Employer group terminated PEBB plan participation; or
- Retiree was determined no longer disabled by the Department of Retirement Systems and stopped receiving a retirement pension.

Identify all qualified beneficiaries

Print name(s) of all qualified beneficiaries who lost coverage due to the initial qualifying event who are still receiving continuation coverage.

Is the address of each qualified beneficiary the same as the employee or retiree? ☐ Yes ☐ No If different, provide address below:

(continued on next page)

Identify second qualifying event (check one and complete)

☐ **Employee and spouse or qualified same-sex domestic partner:**

☐ Divorced ☐ Legally separated ☐ Dissolved the qualified same-sex domestic partnership

Print name of spouse or same-sex domestic partner

Date of divorce, legal separation, or dissolution of partnership (A copy of the decree of divorce or legal separation is required.)

Address of spouse or same-sex domestic partner

☐ **Child ceased to be an eligible dependent under PEBB rules**

Reason: ☐ Attained age that is no longer eligible for PEBB coverage ☐ Loss of student status

☐ Loss of dependent status through divorce, legal separation, or dissolution of qualified same-sex domestic partnership

☐ Married ☐ Other _____

Print name of child

Date of event which caused loss of dependent eligibility

Address of child if different than employee or retiree

☐ **Death of employee or retiree**

Date of employee's or retiree's death _____

Certification, signature, and date

I certify that the above information is true and correct.

I am the (check one): ☐ Former employee or retiree

☐ Spouse or former spouse

☐ Qualified same-sex domestic partner or former qualified same-sex domestic partner

☐ Former dependent child of a qualified same-sex domestic partner

☐ Former dependent child

☐ Other (explain) _____

Signature	Date
Print name	Telephone number ( )

Address

Please sign and date this form.

Return to: Washington State Health Care Authority, PEBB Benefit Services, P.O. Box 42684, Olympia, WA 98504-2684

Washington State law may require disclosure of any information you submit as a public record.
The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Visit our Web site at www.pebb.hca.wa.gov

For HCA Use Only

Date notice of second qualifying event received _____ Date of postmark, if mailed _____

Decree of divorce or legal separation enclosed? ☐ Yes ☐ No ☐ N/A

Public Employees Benefits Board (PEBB)

Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form and Notice Procedures)

This form, including the "Procedures for notice of other coverage, Medicare entitlement, or cessation of disability" section, is part of the *PEBB Initial Notice of COBRA and Continuation Coverage Rights* booklet. For more information about this form, the PEBB's notice procedures, and your COBRA rights and obligations, consult the *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules* and the other sections of the *PEBB Initial Notice of COBRA and Continuation Coverage Rights* booklet. These documents are available by calling PEBB Benefit Services at 1-800-200-1004.

When to use this form

Use this form when any of the following events occurs:

- A qualified beneficiary, after electing COBRA, becomes covered under other group health coverage (but only after any preexisting condition exclusions of the other plan have been exhausted);
- A qualified beneficiary, after electing COBRA, becomes entitled to Medicare (Part A, Part B, or both); or
- The Social Security Administration determines that a disabled qualified beneficiary is no longer disabled, if the maximum period of COBRA coverage previously was extended due to the qualified beneficiary's disability.

Deadline

If you are providing notice of:	The deadline for this notice is:
Other coverage (a qualified beneficiary, after electing COBRA or PEBB Extension of Coverage, becomes covered by other group health plan coverage)	**60 days** after the other coverage becomes effective or, if later, **60 days** after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary
Medicare entitlement (a qualified beneficiary, after electing COBRA , PEBB Extension of Coverage, or PEBB-Sponsored Retiree Coverage becomes entitled to Medicare Part A, Part B, or both)	**60 days** after the beginning of Medicare entitlement (a copy of the Medicare card must be sent with this notice)
Cessation of disability (a Social Security Administration determination that a qualified beneficiary is no longer disabled)	**60 days** after the date of the Social Security Administration's determination (a copy of the Social Security Administration's determination letter must be sent with this notice)

Procedures for notice of other coverage, Medicare entitlement, or cessation of disability

How to provide notice

Your notice **must** be in writing (using the PEBB form included in this notice) and either mailed or hand-delivered. Oral notice (in person or by telephone) and electronic notice (fax or e-mail) is not acceptable.

Where to provide notice

Mailing address
Health Care Authority
PEBB Benefit Services
P.O. Box 42684
Olympia, WA 98504-2684

Street address (for hand deliveries)
Health Care Authority
PEBB Benefit Services
676 Woodland Square Loop SE
Lacey, WA 98503

If mailed, your notice must be postmarked no later than the deadline described on the first page of this notice. If hand-delivered, your notice must be received by PEBB Benefit Services at the address above no later than the deadline described on the first page of this notice.

This contact information may change from time to time. The most recent contact information will be included in the PEBB's current *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules* or by calling PEBB Benefit Services at 1-800-200-1004.

Required form and information

You must use the *Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability* form to notify PEBB Benefit Services of any of these events. All of the applicable items on the form must be completed.

Additional information required for certain notices

- If you are providing **notice of other coverage**, your notice should include evidence of the effective date of other coverage (such as a copy of the insurance card or application for coverage).
- If you are providing **notice of Medicare entitlement**, your notice must include a copy of the Medicare card showing the date of Medicare entitlement before your premiums will reflect the Medicare rate.
- If you are providing **notice of cessation of disability**, your notice must include a copy of the Social Security Administration's determination that the qualified beneficiary is no longer disabled.

Who may provide notice

The employee or former employee who is or was covered under PEBB coverage, a qualified beneficiary (with respect to the qualifying event), or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries with respect to the other coverage, Medicare entitlement, or cessation of disability reported in the notice.

COBRA coverage will terminate regardless of whether or when notice is provided

If a qualified beneficiary first becomes covered by other group health coverage after electing COBRA or PEBB Extension of Coverage, that qualified beneficiary's continuation coverage will terminate (retroactively if applicable) as described in the *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*, regardless of whether or when notice of other coverage is provided.

If a qualified beneficiary first becomes entitled to Medicare Part A, Part B, or both after electing COBRA, that qualified beneficiary's COBRA coverage will terminate (retroactively if applicable) as described in the *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*, regardless of whether or when notice of Medicare entitlement is provided.

If a disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled, continuation coverage for all qualified beneficiaries whose COBRA coverage is extended due to the disability will terminate (retroactively if applicable) as described in the *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*, regardless of whether or when notice of cessation of disability is provided.

If one of the events listed in this notice occurs (except entitlement to Medicare), COBRA coverage will be terminated (retroactively if applicable) as described in the *Summary Plan Description of Continuation Coverage Rights Under COBRA and PEBB Rules*, regardless of whether or when notice of other coverage, Medicare entitlement, or cessation of disability is provided. You are liable for repayment of all benefits paid after the termination date.

Washington State Health Care Authority
Public Employees Benefits Board

Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability

■ Type or print clearly in black ink.

Identify the employee or retiree who was covered under PEBB coverage

Print name of employee	Social security number
Print name of retiree	Social security number

Address of employee or retiree

Identify the initial qualifying event

Initial qualifying event	Date of initial qualifying event

Event description (check one and complete)

☐ **Qualified beneficiary has become covered by other group health coverage after electing COBRA or PEBB Extension of Coverage**

Print name of qualified beneficiary(ies)

Is the address of qualified beneficiary(ies) the same as the employee or retiree? (check one) ☐ Yes ☐ No ☐ If different, provide below

☐ **Qualified beneficiary has become entitled to Medicare after electing COBRA, PEBB Extension of Coverage, or PEBB-sponsored retiree coverage**

Print name of qualified beneficiary(ies) who became entitled to Medicare

Is the address of qualified beneficiary(ies) the same as the employee or retiree? (check one) ☐ Yes ☐ No ☐ If different, provide below

Date Medicare entitlement began for Part A _____ Part B _____

A copy of the qualified beneficiary's Medicare card is required with this notice.

☐ **Qualified beneficiary ceased to be disabled**

Print name of qualified beneficiary

Is the address of qualified beneficiary(ies) the same as the employee or retiree? (check one) ☐ Yes ☐ No ☐ If different, provide below

Date disability ended (according to Social Security Administration's determination)

A copy of the Social Security Administration's determination is required with this notice.

Certification, signature, and date

I certify that the above information is true and correct.

I am the (check one): ☐ Former employee or retiree
☐ Spouse or former spouse
☐ Qualified same-sex domestic partner or former qualified same-sex domestic partner
☐ Former dependent child
☐ Other (explain) _____

Signature	Date
Print Name	Telephone number

Address

Please sign and date this form.

Return to: Washington State Health Care Authority, PEBB Benefit Services, P.O. Box 42684, Olympia, WA 98504-2684

Washington State law may require disclosure of any information you submit as a public record.
The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Visit our Web site at www.pebb.hca.wa.gov

For HCA Use Only

Date notice received _____ Date of postmark, if mailed _____

Type of continuation coverage _____ Election date _____

Evidence of effective date of other coverage enclosed? ☐ Yes ☐ No ☐ N/A

Copy of Medicare card enclosed? ☐ Yes ☐ No ☐ N/A

Social Security determination enclosed? ☐ Yes ☐ No ☐ N/A

Washington State
Health Care Authority
Public Employees Benefits Board

www.pebb.hca.wa.gov